



Office of the  
Arkansas Attorney General  
Dustin McDaniel

**ARKANSAS CRIME VICTIMS  
REPARATIONS BOARD**

**SEXUAL ASSAULT REIMBURSEMENT  
PROGRAM**

**REIMBURSEMENT FORM**  
*(for medical facilities only)*

**Reimbursement will be made ONLY on the following conditions:**

1. Treatment is sought and rendered within 72 hours of the assault. (This will be waived if the victim is a minor or if good cause is shown);
2. The incident was reported to a law enforcement agency;
3. Treatment was not for a pre-existing injury, a physical injury directly relating to the assault, or any other condition; and
4. The victim is not covered by a federally financed benefits program, such as Medicaid, Medicare, Champus or VA. This stipulation has been made pursuant to a VOCA amendment adopted as a part of the Crime Bill.

**SEXUAL ASSAULT VICTIM INFORMATION**

Victim's name \_\_\_\_\_

Victim's date of birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Victim's full address \_\_\_\_\_

Is victim covered by a federally financed benefits program (if yes, please state which program and the victim's identification number)? \_\_\_\_\_

Date and time of assault \_\_\_\_\_

Date and time treatment sought \_\_\_\_\_

Name and address of law enforcement agency notified \_\_\_\_\_

Name and address of medical facility rendering treatment \_\_\_\_\_

Telephone number \_\_\_\_\_ Contact person \_\_\_\_\_

**Was the victim transported by ambulance?** \_\_\_\_\_ If so, please give the name of the ambulance service.

**Was an outside lab facility used to perform or analyze specimens?** \_\_\_\_\_ If so, please give the name of the facility.

### **Transferred victims**

**Was the victim transferred from your facility?** \_\_\_\_\_ If so, please attach documentation justifying the decision to transfer and the name of the facility to whom the victim was sent.

**Was the victim transferred to your facility?** \_\_\_\_\_ If so, please give the name of the facility that transferred the victim.

\_\_\_\_\_

In the case of transferred victims, please be advised that the Sexual Assault Reimbursement Program will not disburse any payments for eligible expenses to either medical facility until the necessary documentation and itemized billing statements are submitted from both the transferring and receiving facility. In addition, these medical facilities must share the allowable award ceilings outlined in the Sexual Assault Reimbursement Program's Policies and Procedures. The Arkansas Crime Victims Reparations Board will determine the appropriate portion of the ceiling for each medical facility on a case-by-case basis.

**Do you have knowledge of the victim incurring expenses with another facility that are related to the sexual assault examination?** \_\_\_\_\_ If so, please give the name of the facility.

### **ATTENDING PHYSICIAN'S OR SANE CERTIFICATION**

Brief description of examination, treatment and tests \_\_\_\_\_

\_\_\_\_\_

I hereby certify that this patient received a medical-legal examination, which included laboratory tests needed by the State to collect evidence for prosecution.

Physician's or SANE signature \_\_\_\_\_ Date \_\_\_\_\_

### **LAW ENFORCEMENT OR VICTIM ASSISTANCE COORDINATOR**

I hereby certify that the named law enforcement agency received a report that the victim had been sexually assaulted. The information contained in the application is true and correct to the best of my knowledge or belief.

\_\_\_\_\_

(Law enforcement/victim witness coordinator/verified victim advocate signature)

Title/Agency \_\_\_\_\_

Date \_\_\_\_\_ Badge Number \_\_\_\_\_

\_\_\_\_\_

Pursuant to Arkansas Code Annotated 12-12-404, the Crime Victims Reparations Board will reimburse a medical facility for costs incurred in performing a medical-legal examination and tests for venereal disease on sexual assault victims. The medical facility must complete all sections, including the necessary signatures. A copy of the itemized bill (including current procedural terminology (CPT) codes), along with any other relevant information to substantiate the claim must be attached to this form to ensure payment. NOTE: In compliance with Arkansas Code Annotated 12-12-403, the medical facility or licensed health care provider shall not submit any remaining balance after reimbursement by the Arkansas Crime Victims Reparations Board to the victim. Additionally, acceptance of payment of the expenses of the medical-legal examination by the Arkansas Crime Victims Reparations Board shall be considered payment in full and bars any legal action for collection. Information should be forwarded to the **Arkansas Crime Victims Reparations Board, 323 Center Street, Suite 200, Little Rock, AR 72201. You may fax the form and itemized statement to (501) 682-5313 or (501) 683-5569. Questions may be directed to 1-800-448-3014 or (501) 682-1020.**